

\* The original of this document contains information which is subject to withholding from disclosure under 5 U.S.C. 552. Such material has been deleted from this copy and replaced with XXXXXX's.

February 26, 2008

DEPARTMENT OF ENERGY  
OFFICE OF HEARINGS AND APPEALS

Hearing Officer's Decision

Name of Case: Personnel Security Hearing

Date of Filing: September 12, 2007

Case Number: TSO-0543

This Decision concerns the eligibility of XXXXXXXXXXXX (hereinafter "the Individual") for access authorization. The regulations governing the Individual's eligibility are set forth at 10 C.F.R. Part 710, "Criteria and Procedures for Determining Eligibility for Access to Classified Matter or Special Nuclear Material." This Decision will consider whether, based on the testimony and other evidence presented in this proceeding, the Individual's suspended access authorization should be restored. For the reasons detailed below, I have concluded that the Individual's access authorization should be restored.

I. Background

The Individual has been a DOE contractor employee and held a clearance for many years. When he applied for a clearance in 1988, he disclosed a 1983 hospitalization for an "acute reactive psychosis." DOE Ex. 15. The Local Security Office (LSO) referred him to a DOE consultant-psychiatrist (DOE Psychiatrist I), who opined that the 1983 hospitalization involved a "manic depressive (bipolar affective disorder) episode." DOE Ex. 13 at 11. DOE Psychiatrist I further opined that the risk of another episode was less than 50 percent and, therefore, medication was unwarranted. *Id.* Finally, DOE Psychiatrist I commented that reports indicated that the Individual was "an exceptionally well-adjusted, creative, and sociable person." *Id.* at 12. The Individual was granted a clearance.

The Individual had a depressive episode in 2002 and a manic episode in 2002, and again, in 2005. As a result, the Local Security Office (LSO) referred the Individual to a DOE consultant-psychiatrist (DOE Psychiatrist II) for an evaluation.

In his 2006 report, DOE Psychiatrist II opined that the Individual had Bipolar I Disorder, citing the criteria set forth in the American Psychiatric Association Diagnostic and Statistical Manual (DSM-IV-TR). DOE Ex. 3 at 8-12. The Individual's manic episodes were "severe" and the depressive episodes "significant." *Id.* at 12. An antidepressant likely contributed to the 2002 episode. *Id.* After that episode, the Individual took Depakote for over a year, but then unilaterally discontinued the medication, citing weight gain and sleep apnea. *Id.* at 6. The absence of Depakote likely contributed to the 2005 episode. *Id.* at 12. The Individual was restarted on Depakote after the 2005 episode and was free of symptoms between that time and the psychiatrist interview. *Id.* at 7. During the psychiatric interview, the Individual expressed a good understanding of his illness and stated that he recognized that he needed to be on Depakote the rest of his life. *Id.* He reported taking Depakote twice a day and missing about one dose a week. *Id.* The Individual's history of severe episodes and poor judgment in managing the disorder left the Individual at "high" risk for a future episode. *Id.* at 12-13. In sum, DOE Psychiatrist II found that the Individual's disorder had caused defects in judgment and reliability and was "likely" to do so in the future. *Id.* at 13.

In 2007, the LSO issued a Notification Letter, which cited a concern that the Individual has a mental illness that may cause a defect in judgment and reliability. DOE Ex. 1 (Statement of Charges), citing 10 C.F.R. § 708.8(h) (Criterion H). The Individual requested a hearing, and I was appointed to serve as the Hearing Officer.

## II. The Hearing

### A. Written Evidence

Both parties submitted exhibits. The DOE exhibits included the reports of DOE Psychiatrists I and II. The Individual's exhibits included a chronology, a letter from a treating psychiatrist (Treating Psychiatrist I), a treatment plan developed in conjunction with his doctors, laboratory reports of his Depakote levels, several articles on Bipolar I Disorder, and performance appraisals and awards.

The letter from Treating Psychiatrist I discusses the Individual's treatment and prognosis. Ind. Ex. 7. Treating Psychiatrist I reported that Depakote was "working well" and the Individual's mood was "uniformly stable." *Id.* She stated that

the Individual intended to increase his dietary and exercise regimen to address his weight gain and cardiac risk and was considering blood lipid-lowering medication. *Id.* She opined that the Individual could still have a manic or depressive episode, but these would be "far decreased in intensity as well as in frequency." *Id.*

The Individual's treatment plan discusses medication, the roles of Treating Psychiatrist I and a second psychiatrist (Treating Psychiatrist II) in the Individual's treatment, and the Individual's responsibilities. Ind. Ex. 13. Under the plan, the Individual is monitored on a monthly basis by Treating Psychiatrist I, with Treating Psychiatrist II consulted in connection with any medication adjustments. *Id.* Medication is Depakote daily, with blood levels measured regularly, and Olanzapine in the event of the onset of "trigger conditions" for a Bipolar I episode. *Id.* See also Ind. Ex. 15 (laboratory reports). The Individual maintains a daily log, which monitors mood, sleep, medicine, exercise, and stress. Ind. Ex. 13. See also Ind. Ex. 14 (completed November 2007 log). As the testimony at the hearing made clear, this treatment plan was prepared in conjunction with Treating Psychiatrists I and II.

The articles on Bipolar I Disorder discuss the role of medication in that disorder. Ind. Exs. 4-6. The first article discusses research on the benefits of mood stabilizers; the second and third discuss antidepressant-induced mania and the risk of antidepressants for individuals with Bipolar I Disorder.

Other documents relate to the Individual's functioning in the workplace. Performance appraisals for the last five years are positive. Ind. Ex. 10. In his 2007 performance appraisal, the Individual's manager reports that the Individual had an "outstanding year" and "excelled in all areas." Ind. Ex. 10 at 2. A group of certificates and awards reflect accomplishments. Ind. Ex. 11. Finally, a credit report is positive. Ind. Ex. 12.

#### B. Testimony

DOE presented one witness - DOE Psychiatrist II. The Individual, who was represented by counsel, testified and presented seven witnesses: his mother, his supervisor, four current or former colleagues, and Treating Psychiatrist II.

## 1. The Individual

The Individual testified that he has Bipolar I Disorder. Tr. at 119. It is "a chronic disease" which must be "actively managed." *Id.* at 119-21. The Individual began seeing Treating Psychiatrist II two months before the hearing, and has seen him four or five times since then. *Id.* at 170.

The Individual described his current treatment plan. Tr. at 120-22. He takes Depakote, which is doing a "good job" of stabilizing his moods. *Id.* at 157. In addition, he is monitoring his moods and triggering conditions on a daily basis in order to allow him to "nip [a potential bipolar episode] in the bud." *Id.* at 158. If a triggering condition occurs, the Individual will take Olanzapine and contact the treating psychiatrists. *Id.* at 154-55.

The Individual testified that his current treatment plan is an effective plan. In particular, he noted that the recent episodes - those in 2000, 2002, and 2005 - were preceded by several symptoms, including trouble sleeping. Tr. at 123-25, 134, 140-2. Under his current treatment plan, he would have identified the symptoms at once, taken Olanzapine, and contacted the treating psychiatrists. *Id.* at 164. Moreover, he is not taking an antidepressant, which was a factor in the 2002 manic episode. *Id.* at 125, 132.

Finally, the Individual testified that he was committed to following his treatment plan. He stated that, until recently, he was not well-informed about his illness and was concerned about his weight gain while taking Depakote. Tr. at 159-60. Discontinuing Depakote in 2003 was a "mistake," *id.* at 138, and he has "come to grips" with the weight gain, *id.* at 160. He will not modify his medication in the absence of the agreement of the treating psychiatrists. *Id.* at 139. He will also minimize the types of schedule disruptions associated with his prior episodes. *Id.* at 155-56. Finally, he has told family, friends, and colleagues about his illness and his symptoms. *Id.* at 161-62.

## 2. The Individual's Mother

The Individual's mother testified concerning the Individual's mental health and treatment. She described him as active in activities during junior and senior high school; the 1983 episode was the first indication of a problem. Tr. at 76-87. By the summer of 1983, his treatment was completed. *Id.* at 87.

After that, the Individual did not have any problems through the 1980s and 1990s. *Id.* at 88. She testified that at the time of the 2000 episode, the Individual "wasn't feeling well" and travelled to his parents' home. *Id.* at 87-88. The Individual saw the psychiatrist who treated him in 1983. *Id.* at 89. In the first part of 2002, he had another episode for which he was hospitalized. *Id.* at 93. The treating psychiatrist, noting that the Individual had been on an antidepressant, stated that "he should never have been on" that medication. *Id.* at 96. The Individual was prescribed Depakote and was back to work in two weeks. *Id.* at 98. The Individual's mother was aware that he later stopped taking the Depakote: "[H]e just said that it was causing him to have a weight gain, and he was feeling good and he didn't think he needed it." *Id.* at 104. She stated that "he's learned his lesson," referring to the 2005 episode. *Id.* at 106. The Individual's mother testified that she and his father were part of his support system and had telephone numbers for his physicians and friends. *Id.* at 108-10.

### 3. The Individual's Supervisor

The Individual's supervisor (the Supervisor) testified that the Individual was a "very solid performer." *Tr.* at 10. The Individual is "technically very, very sound." *Id.* The Supervisor has not seen anything to indicate that the Individual is not trustworthy. *Id.* at 17-18. The Individual informed the Supervisor of his illness and its symptoms. *Id.* at 13.

### 4. The Individual's Colleagues

The first colleague testified that he had known the Individual since the early 1990's. *Tr.* at 12-13. The colleague had a "very good" relationship with the Individual. *Id.* at 30. The issue of the Individual's mental condition "came as a complete surprise." *Id.* at 29. The colleague "never observed anything that I thought was affecting his judgment, or [that he was] unduly depressed or euphoric." *Id.* at 33. In sum, the Individual is a "valuable colleague, and his technical work has been superb." *Id.* at 34.

The second colleague has known the Individual for about ten years. *Tr.* at 37. The colleague testified that the Individual is "an extremely hard worker, very conscientious," and "someone I really like having around." *Id.* at 43. The Individual informed the colleague of his condition and its symptoms. *Id.* at 52-53. In sum, the Individual is "very consistent, very

reliable, very conscientious, gives us everything you'd like in an employee." *Id.* at 55.

The third colleague has known the Individual for five years. *Tr.* at 59. "All of our work-related stuff, I would say was friendship-related as well." *Id.* at 62. The colleague did not know the Individual had a bipolar disorder until recently and "would have never ventured a guess that there was a problem of that type." *Id.* at 64. In sum, the colleague "could not think of a better person to work with." *Id.* at 65.

The fourth colleague has known the Individual since the mid-1990s. *Tr.* at 68. The colleague and the Individual worked on a project for about four years and saw each other "more than weekly, often daily." *Id.* at 69. The project involved a challenging workload, but "there was nothing about [the Individual's] behavior that indicated that he was reacting to that any differently" from others in a similar situation. *Id.* at 73. Since then, the Individual and the colleague have "crossed paths roughly once a year." *Id.* at 70. The Individual recently told the colleague about his bipolar disorder. *Id.* at 72.

#### 5. Treating Psychiatrist II

Treating Psychiatrist II testified that the Individual's Bipolar I Disorder is in remission and that it is unlikely that he will have another episode. *Tr.* at 202, 209. The Individual's recovery time following episodes has gone down, his treatment plan is good, and the Individual is committed to following the plan. *See, e.g., id.* at 189-93. The frequency of his blood tests to measure his Depakote level is reasonable, and his tests over the past year show that his levels are in the therapeutic range. *Id.* at 201-02. The Individual has a good therapeutic relationship with the treating psychiatrists. *Id.* at 201-02, 204. In response to a suggestion from Treating Psychiatrist II, the Individual developed the mood chart. *Id.* at 218. The Individual has a "sense of relief" that he understands his illness and that he has a treatment plan that will allow him to act proactively to avoid another episode. *Id.* at 204.

#### 6. DOE Psychiatrist II

DOE Psychiatrist II was present throughout the hearing. He testified last.

DOE Psychiatrist II discussed the Individual's illness, giving particular attention to the 2002 and 2005 manic episodes. Tr. at 222, 224-25. DOE Psychiatrist stated that Depakote lowers the likelihood of a recurrence but "it doesn't help at all if you don't take it." *Id.* at 226. When DOE Psychiatrist II interviewed the Individual, DOE Psychiatrist II was concerned about the Individual's history of "poor compliance." *Id.*

DOE Psychiatrist II testified that the Individual had made "positive" changes since the psychiatric interview. Tr. at 231. The Individual is "much better educated" and "taking the disorder much more seriously." Tr. at 232. The Individual has "come to more of an acceptance" of the disorder. *Id.* at 231. The Individual has a "much more rigorous treatment plan" than at the time of the interview. *Id.* The provision for taking Olanzapine, as needed, is "very helpful." *Id.* at 231. The Individual's understanding of the illness and the plan's strict regimen give him better compliance. *Id.* at 231-32. The Individual is "perfectly compliant" with medicines, as shown by the Depakote levels. *Id.* at 232. The plan is an "excellent treatment" plan, and there are no areas in which it could be improved. *Id.* at 234.

As a result of those positive changes, DOE Psychiatrist II rendered an updated opinion on the Individual's prognosis. The Individual's probability of having an episode in future years is "much improved" and low. Tr. at 232-33. Accordingly, the DOE Psychiatrist II saw "adequate evidence of reformation or rehabilitation" i.e., a "low" risk of a future episode. *Id.*

## II. Applicable Regulations

The regulations governing an individual's eligibility for access authorization (also referred to as a security clearance) are set forth at 10 C.F.R. Part 710, "Criteria and Procedures for Determining Eligibility for Access to Classified Matter or Special Nuclear Material." An individual is eligible for access authorization if such authorization "would not endanger the common defense and security and would be clearly consistent with the national interest." 10 C.F.R. § 710.7(a). "Any doubt as to an individual's access authorization eligibility shall be resolved in favor of the national security." *Id.* See generally *Dep't of the Navy v. Egan*, 484 U.S. 518, 531 (1988) (the "clearly consistent with the interests of national security" test indicates that "security-clearance determinations should err, if they must, on the side of denials"); *Dorfmont v. Brown*,

913 F.2d 1399, 1403 (9<sup>th</sup> Cir. 1990) (strong presumption against the issuance of a security clearance).

If a question concerning an individual's eligibility for a clearance cannot be resolved, the matter is referred to administrative review. 10 C.F.R. § 710.9. The individual has the option of obtaining a decision by the manager at the site based on the existing information or appearing before a hearing officer. *Id.* § 710.21(b)(3). At a hearing, the burden is on the individual to present testimony or evidence to demonstrate that he is eligible for access authorization, *i.e.*, that access authorization "will not endanger the common defense and security and will be clearly consistent with the national interest." *Id.* § 710.27(a).

#### IV. Analysis

The LSO correctly concluded that the Individual's Bipolar I Disorder diagnosis raises a security concern. A security concern arises if an individual is diagnosed with a mental condition that may affect judgment and reliability. 10 C.F.R. § 710.8(h). It is undisputed that (i) Bipolar I Disorder is a mental condition that may cause a defect in judgment and reliability and (ii) the Individual has that disorder.

To resolve this type of concern, an individual must demonstrate that the risk of a defect in judgment and reliability is low. To do that, an individual must demonstrate that (i) the condition has been stabilized, (ii) an effective treatment plan is in place, and (iii) the individual is likely to follow the plan. *See, e.g., Personnel Security Hearing, Case No. TSO-0428, 29 DOE ¶ 83,015 (2006).*

In this case, the Individual brought forward extensive evidence and testimony concerning his stability, his current treatment plan, and his commitment to that plan. As of the time of the hearing, he had not had an episode since 2005, had a heightened understanding of his condition, a commitment to taking medication regardless of the side effects, and a daily regimen to identify triggering conditions and "nip them in the bud." *See, e.g., Ind. Exs. 4-6 (articles on medication for bipolar disorder); Ind. Ex. 7 (letter from Treating Psychiatrist I); Ind. Ex. 13 (treatment plan); Ind. Ex. 14 (November 2007 log).* The testimony of Treating Psychiatrist II corroborates the Individual's description of his treatment. *Tr.* at 186-219. Importantly, the laboratory reports and testimony from both Treating Psychiatrist II and DOE Psychiatrist II corroborate the

Individual's testimony that he is taking the Depakote as prescribed. Ind. Ex. 15; Tr. at 201-02, 232. Finally, the Individual has presented witnesses to corroborate his testimony that he has a support network. Id. at 13 (colleague), 52-53 (colleague), 108-110 (mother, discussing family and friends).

The medical experts agree that the Individual's risk of relapse is low. Tr. at 209, 232-33. In that respect, the record provides ample support for the updated assessment by DOE Psychiatrist II. When he interviewed the Individual in 2006, the 2005 episode was relatively recent. As discussed above, by the time of the hearing, the Individual had over two years without an episode, a more rigorous treatment plan, and greater knowledge of, and commitment to, his treatment plan.

In sum, the evidence and testimony indicates that the Individual's risk of another bipolar episode is low and, therefore, it is unlikely to cause a defect in judgment and reliability. Accordingly, the security concern arising from the bipolar diagnosis is resolved.

#### V. Conclusion

The Individual has resolved the Criterion H concern set forth in the Notification Letter. As a result, restoring the Individual's access authorization "would not endanger the common defense and security and would be clearly consistent with the national interest." 10 C.F.R. § 710.7(a). Accordingly, I have concluded that the Individual's access authorization should be restored. Any party may seek review of this Decision by an Appeal Panel under the procedures set forth at 10 C.F.R. § 710.28.

Janet N. Freimuth  
Hearing Officer  
Office of Hearings and Appeals

Date: February 26, 2008